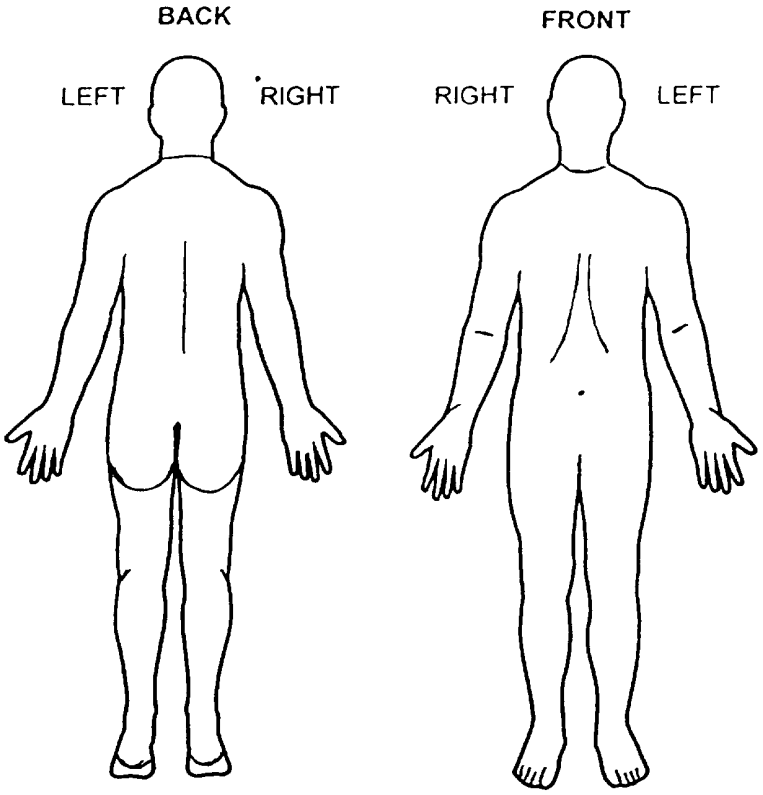
*Dr. Z's Acupuncture Clinic, Inc.*
*Norman Zavela, M.D., F.A.A.M.A.*
*3775 Truman Road Perrysburg, OH 43551*
*(419) 346-9202*

**Patient Questionnaire** **Name:**_____
**Date:**_____

Indicate problem area with an "X"
Indicate to where symptoms move with an arrow "→"




Which words describe your pain or problem?

- ❑ Ache
- ❑ Burning
- ❑ Hot
- ❑ Cold
- ❑ Pins / Needles
- ❑ Stabbing
- ❑ Numbness
- ❑ Pressure

Other - _____
_____
_____
_____
_____
_____
_____
_____

Please rate the severity of symptoms (circle one):

| 0 - 1 - 2 | 3 - 4 | 5 - 6 | 7 -8 | 9 - 10 |
|---|---|---|---|---|
| None/mild | | Moderate | | Severe |

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## Patient Questionnaire

*Please complete this questionnaire as accurately as possible. This information will assist your doctor to evaluate and treat your problem. This form must be filled out for each new problem. PRINT CLEARLY*

**Name:**_____. **Age:**_____.
**Family doctor:**_____.
**Occupation:**_____.
**Currently employed?** □ **Yes** □ **No If no, date you last worked:**_____.

**Main complaint or problem:**_____.
**Date of injury / start of problem:**_____.
**How did your problem start?**_____.
**Describe any treatments you have had for this problem:**_____.
_____.
**Is the problem getting:** □ **Better** □ **Worse** □ **Staying the same**
**What makes it better?**_____.
**What makes it worse?**_____.
**What can't you do because of this problem?**_____.

**List any medical conditions you are CURRENTLY being treated for:**
_____.
_____.
_____.
**Previous medical conditions:**_____.
_____.
**List all surgeries you have had and year surgery was performed:**
_____.
_____.
_____.

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**Patient Questionnaire** **Name:**_____

**Do you use any of the following?** **Amount used**

- ❑ Tobacco _____
- ❑ Alcohol _____
- ❑ Caffeine _____
- ❑ Illegal chemical substances _____
- ❑

**List all your current medications (including herbs and vitamins):**

| Drug Name | Dosage | How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**List any allergies you have to medications:** ☐ None

| Drug Name | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Thank you for taking the time to fill in this questionnaire.**
**Patient signature:** _____